CalOptima
A Public Agency
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CalOptima Health Homes Program Referral Form

Please complete this referral form and fax to ______________________________. Eligible members will be directly contacted by their health network with information regarding their designated care coordinator.

Date: ____________________

Contact Person: ____________________________ Phone/email: _________________________

Member Name: ____

Date of Birth: _________________________ Primary Phone: ____________________________

Medi-Cal CIN: _________________________ Secondary Phone: _________________________

Primary Care Provider Name/Agency/Phone: ____

#1: Please check all diagnoses that apply and attach documentation of diagnoses as available

Physical Health Conditions	Mental Health Conditions	Substance Use Disorders
☐ Chronic Obstructive Pulmonary Disease ☐ Diabetes ☐ Traumatic Brain Injury ☐ Chronic or Congestive Heart Failure ☐ Coronary Artery Disease ☐ Chronic Liver Disease ☐ Chronic Renal Disease ☐ Dementia ☐ Hypertension ☐ Asthma	☐ Major Depression Disorders ☐ Bipolar Disorder ☐ Psychotic Disorders	☐ Chronic Alcohol Abuse ☐ Alcohol Liver Disease ☐ Cocaine Abuse ☐ Opioid Abuse ☐ Substance Abuse ☐ Other: _______________

#2: Please check any categories below that pertain to the member being referred

Poor Connectivity to Care	
☐ No primary care provider ☐ No connection to specialty doctor or other practitioner ☐ Difficulty with compliance (does not keep appointments, non-adherence to medications, etc.) ☐ Inappropriate emergency department use (3 or more in 12 months)	☐ Recent release from incarceration ☐ Chronic homelessness ☐ Cannot be effectively treated in an appropriately resourced patient centered medical home ☐ Repeated recent hospitalizations for preventable conditions (medical or psychiatric — 2 or more in 12 months) ☐ Other: ____________________________

Other Significant Behavioral, Medical or Social Risk Factors	
☐ Recent discharge from psychiatric hospitalization ☐ Probable risk for adverse event ☐ Lack of/inadequate social, family or housing support	☐ Deficits in Activities of Daily Living ☐ Learning or cognition issues ☐ Other: ______________________________

Health Homes Program (HHP) Health Network Contact Information

Health Network	Member Phone Number	Referral Fax Number
AltaMed Medical Group	866-880-7805 (option 1, then 3)	323-201-3225
AMVI Care Health Network	714-347-5843	714-938-5168
CHOC Health Alliance (CHOC)	800-387-1103	714-628-9178
CalOptima Direct / CalOptima Community Network (COD/CCN)	**888-587-8088**	**714-481-6432**
Family Choice Medical Group	800-611-0111	818-817-5155
Heritage-Regal Medical Group	844-292-5173	714-244-4537
Kaiser Permanente	866-551-9619	877-515-6591
Noble Mid-Orange County	714-699-5143	714-947-8796
Optum Care Network — Arta	800-780-8879	714-436-4716
Optum Care Network — Monarch	888-656-7523	949-923-3572
Optum Care Network — Talbert	800-297-6249	714-436-4716
Prospect Medical Group	714-347-5843	714-938-5168
United Care Medical Group	714-347-5843	714-938-5168